

may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03339

## CERTIFICATE OF DEATH

03344

Reg. Dist. No. 290

1. PLACE OF DEATH o. COUNTY <u>TALBOT</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>TALBOT</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>EASTON</u>				c. LENGTH OF STAY IN 1b <u>50 hrs 45 min</u> x2 <u>OXFORD</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>MEMORIAL HOSPITAL</u>				d. STREET ADDRESS <u>1</u>			
3. NAME OF DECEASED (Type or print) First <u>ADDIE</u> Middle <u>I</u> Last <u>ABBOTT</u>				4. DATE OF DEATH Month <u>MARCH</u> Day <u>24</u> Year <u>1957</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2/8/1891</u>	9. AGE (In years last birthday) <u>66</u> yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	
13. FATHER'S NAME <u>THOMAS ELLIOTT</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
17. INFORMANT				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Metastatic Colloid Adeno-</u> <u>153X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Carcinoma of Cecum</u> DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH <u>8 yrs.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. 11. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>1-6-</u> , 19 <u>57</u> , to <u>3-24-</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>3-24-</u> , 19 <u>57</u> , and that death occurred at <u>3:30 P.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Donald H. Bentley</u> M.D.				ADDRESS (Street, city or town, state) <u>9 N. Hanson St. Easton, Md.</u>			
DATE SIGNED <u>3-25-57</u>							
PHYSICIAN'S NAME (Type) <u>Easton, Md.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>3/26/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Belwood Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Belwood Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Maude E. Newnam</u>				ADDRESS <u>Lois Easton</u>		24a. REC'D BY REGISTRAR <u>3/26/57</u>	
				24b. REGISTRAR'S SIGNATURE <u>N. A. Neerue</u>			

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03340

CERTIFICATE OF DEATH

03345

Reg. Dist. No. 290

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Queen Anne's</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>				c. LENGTH OF STAY IN 1b <u>10 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Memorial Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Beatrice</u> Middle <u>C</u> Last <u>Anthony</u>				4. DATE OF DEATH Month <u>3</u> Day <u>27</u> Year <u>1957</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>December 3, 1894</u>	
9. AGE (In years last birthday) <u>62</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				13. FATHER'S NAME <u>Charles E. Cannon</u>			
14. MOTHER'S MAIDEN NAME <u>Hattie Cline</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO. <u>NONE</u>				17. INFORMANT <u>Mr. Bill Anthony</u> Address <u>Centerville, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Thrombosis of abdominal aorta</u> 451X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Generalized atherosclerosis</u> DUE TO (c) <u>(?)</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Coronary atherosclerosis &amp; pulmonary emphysema</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour <u>o. n.</u> <u>19</u> p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>March 17, 1957</u> , to <u>27 Mar</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>26 Mar</u> , 19 <u>57</u> , and that death occurred at <u>4:35 A.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Thurston Harrison</u> M.D.				DATE SIGNED <u>28 Mar 57</u>			
PHYSICIAN'S NAME (Type) <u>THURSTON HARRISON</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3/29/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Chesterfield Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Centerville, Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Betty B. by J. H. B. by J. H. B.</u>				ADDRESS <u>Centerville, Md.</u>		24a. REC'D BY REGISTRAR <u>DATE 3/29/57</u>	
24b. REGISTRAR'S SIGNATURE <u>N. H. Neerix</u>							

## KAYLAND STATE DEPARTMENT OF HEALTH—JALINGHOE 12

**BUREAU V. S.**

APR 2 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03341

CERTIFICATE OF DEATH

03346

Reg. Dist. No. 290

1. PLACE OF DEATH a. COUNTY <u>Telbot</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Queen Annes</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>				c. LENGTH OF STAY IN 1b <u>24 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Memorial</u>				d. STREET ADDRESS <u>Stevensville 17802</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <u>John J. ANZER</u>				4. DATE OF DEATH Month Day Year <u>March 3 1957</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>January 23, 1887</u>		9. AGE (In years last birthday) <u>70</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Joseph Anzer</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth Gould</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Mrs Katherine Anzer</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> <u>292.4</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Aplastic Anemia</u> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>March 1, 1957</u> , to <u>March 3, 1957</u> , that I last saw the deceased alive on <u>March 3, 1957</u> , and that death occurred at <u>9:00 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>E.C.H. Schmidt</u> M.D.				ADDRESS (Street, city or town, state) <u>219 S Westminister St</u>			
PHYSICIAN'S NAME (Type) <u>E.C.H. Schmidt</u>				DATE SIGNED <u>6 Mar 57</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3/6/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Stevensville Md.</u>		22d. LOCATION (City, town, or county) (State) <u>Stevensville Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edgar L. Lane Church Hill Md</u>				24a. REC'D BY REGISTRAR DATE <u>3/6/57</u>		24b. REGISTRAR'S SIGNATURE <u>N.H. Devine</u>	

RECEIVED



03342

## CERTIFICATE OF DEATH

03347

Reg. Dist. No. 290

1. PLACE OF DEATH o. COUNTY <u>TALBOT</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>TALBOT</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>EASTON</u>				c. LENGTH OF STAY IN 1b <u>25 1/2 Hrs.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X2. SHERWOOD</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>MEMORIAL HOSPITAL</u>				d. STREET ADDRESS <u>1</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>GEORGE FREDERICK BENHOFF</u>				4. DATE OF DEATH Month <u>MARCH</u> Day <u>25</u> Year <u>1957</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1/16/1873</u>		9. AGE (In years last birthday) <u>84</u> yrs.	IF UNDER 1 YEAR: IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>PETROLEUM ENG. (OIL INDUSTRY)</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>GEORGE F. BENHOFF</u>				14. MOTHER'S MAIDEN NAME <u>LENA SMITH</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>-</u>		17. INFORMANT <u>EARL C. BENHOFF (son)</u> Address <u>SPRINGFIELD, N.J. 116 So. MAPLE ST</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute peritonitis</u> <u>587.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Acute pancreatitis</u> DUE TO (c) <u>Cholelithiasis</u>						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____, _____, _____, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>E. C. H. Schmidt</u>				ADDRESS (Street, city or town, state) <u>219 S. West Washington St. 25 Mar 57</u>			
PHYSICIAN'S NAME (Type) <u>E. C. H. Schmidt</u>				DATE SIGNED <u>25 Mar 57</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3/28/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Trinity</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Hampton Harrison, St. Michael's Md</u>				24c. REC'D BY REGISTRAR <u>DATE 3/28/57</u>		24b. REGISTRAR'S SIGNATURE <u>N. H. Newlin</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

APR 2 1957

RECEIVED



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03343

CERTIFICATE OF DEATH

03348

Reg. Dist. No. 290

1. PLACE OF DEATH a. COUNTY <b>Talbot</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Talbot</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Easton</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Easton</b>			
c. LENGTH OF STAY IN 1b <b>35</b>				d. STREET ADDRESS <b>117 South Lane</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>WILLIE EMMA CHRISTOPHER</b>				4. DATE OF DEATH <b>March 19, 1957</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>June 26, 1896</b>	
9. AGE (In years last birthday) <b>60</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				11. BIRTHPLACE (State or foreign country) <b>Maryland</b>			
10b. KIND OF BUSINESS OR INDUSTRY				12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>			
13. FATHER'S NAME <b>Peter Jester</b>				14. MOTHER'S MAIDEN NAME <b>Laura Fleetwood</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
17. INFORMANT <b>Mrs. Mabel Boyce</b> Address <b>Oxford, Md.</b>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Metastatic Carcinoma of Lung, left</b> DUE TO (b) <b>Carcinoma of sigmoid</b> DUE TO (c) <b>Attnk of University of Maryland, oncology</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Die bite Mollusca (yrs)</b> INTERVAL BETWEEN ONSET AND DEATH <b>6 mos</b> <b>4 yrs</b> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <b>1-1</b> , 19 <b>47</b> , to <b>3-19</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>3-18</b> , 19 <b>57</b> , and that death occurred at <b>3:00</b> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Martin F. Buell</b> M.D.				DATE SIGNED <b>3-20-57</b>			
PHYSICIAN'S NAME (Type) <b>Dr. Martin F. Buell</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>March 21, 1957</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Spring Hill Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Easton, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Maurice E. Newnam &amp; Son</b> ADDRESS <b>Easton, Md.</b>				24a. REC'D BY REGISTRAR <b>DATE 3-21-57</b>		24b. REGISTRAR'S SIGNATURE <b>N.A. Neerix</b>	

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF DEATH		PLACE OF DEATH	
JAMES M. JONES		45		M		W		1957		BALTIMORE, MD.	
MARRIAGE		DATE		PLACE		DATE OF MARRIAGE		PLACE OF MARRIAGE		DATE OF DEATH	
MARRIED		1955		BALTIMORE, MD.		1955		BALTIMORE, MD.		1957	
EDUCATION		SCHOOLING		SCHOOLING		SCHOOLING		SCHOOLING		SCHOOLING	
HIGH SCHOOL		HIGH SCHOOL		HIGH SCHOOL		HIGH SCHOOL		HIGH SCHOOL		HIGH SCHOOL	
UNIVERSITY		UNIVERSITY		UNIVERSITY		UNIVERSITY		UNIVERSITY		UNIVERSITY	
OCCUPATION		OCCUPATION		OCCUPATION		OCCUPATION		OCCUPATION		OCCUPATION	
LABORER		LABORER		LABORER		LABORER		LABORER		LABORER	
CAUSE OF DEATH		CAUSE OF DEATH		CAUSE OF DEATH		CAUSE OF DEATH		CAUSE OF DEATH		CAUSE OF DEATH	
HEART DISEASE		HEART DISEASE		HEART DISEASE		HEART DISEASE		HEART DISEASE		HEART DISEASE	
MURDER		MURDER		MURDER		MURDER		MURDER		MURDER	
SUICIDE		SUICIDE		SUICIDE		SUICIDE		SUICIDE		SUICIDE	
OTHER		OTHER		OTHER		OTHER		OTHER		OTHER	
DATE OF DEATH		DATE OF DEATH		DATE OF DEATH		DATE OF DEATH		DATE OF DEATH		DATE OF DEATH	
1957		1957		1957		1957		1957		1957	
PLACE OF DEATH		PLACE OF DEATH		PLACE OF DEATH		PLACE OF DEATH		PLACE OF DEATH		PLACE OF DEATH	
BALTIMORE, MD.		BALTIMORE, MD.		BALTIMORE, MD.		BALTIMORE, MD.		BALTIMORE, MD.		BALTIMORE, MD.	
DATE OF DEATH		DATE OF DEATH		DATE OF DEATH		DATE OF DEATH		DATE OF DEATH		DATE OF DEATH	
1957		1957		1957		1957		1957		1957	
PLACE OF DEATH		PLACE OF DEATH		PLACE OF DEATH		PLACE OF DEATH		PLACE OF DEATH		PLACE OF DEATH	
BALTIMORE, MD.		BALTIMORE, MD.		BALTIMORE, MD.		BALTIMORE, MD.		BALTIMORE, MD.		BALTIMORE, MD.	

BUREAU V. 2

MAR 26 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03349

03344

## CERTIFICATE OF DEATH

Reg. Dist. No. 290

1. PLACE OF DEATH a. COUNTY <i>Talbot</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Talbot</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Easton</i>				c. LENGTH OF STAY IN 1b <i>8 da</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>no Ox Ford</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Memorial Hospital</i>				d. STREET ADDRESS <i>1</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>Aubrey</i> Middle <i>Cox</i> Last <i>Cox</i>				4. DATE OF DEATH Month <i>9</i> Day <i>21</i> Year <i>1957</i>			
5. SEX <i>male</i>		6. COLOR OR RACE <i>W</i>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>Sept. 23, 1878</i>	
9. AGE (In years last birthday) <i>78</i> yrs.		IF UNDER 1 YEAR Months <i>78</i> Days <i>78</i> Hours <i>78</i> Min. <i>78</i>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <i>md.</i>	
11. BIRTHPLACE (State or foreign country) <i>U.S.A.</i>				12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>			
13. FATHER'S NAME <i>Spedden O. Cox</i>				14. MOTHER'S MAIDEN NAME <i>Ella Adams</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>		16. SOCIAL SECURITY NO. <i>no</i>		17. INFORMANT <i>Mrs Myra L. Cox (wife)</i>		Address <i>Cox (wife)</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Myocardial infarction</i> 420.1 DUE TO <i>Coronary narrowing</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Arteriosclerosis</i> (c) <i>Arteriosclerosis</i>						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour <i>o. ft.</i> Month <i>19</i> Day <i>19</i> Year <i>19</i> p.m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				(County)		(State)	
21. I certify that I attended the deceased from <i>12/10/57</i> , 19____, to <i>5/21/57</i> , 19____, that I last saw the deceased alive on <i>5/21/57</i> , 19____, and that death occurred at <i>5 A. M.</i> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>E.C.H. Schmidt</i>				ADDRESS (Street, city or town, state) <i>2195 West 117th St ST 27 May 57</i>			
PHYSICIAN'S NAME (Type) <i>E.C.H. Schmidt</i>				DATE SIGNED <i>5/21/57</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>May 23, 1957</i>		22c. NAME OF CEMETERY OR CREMATORY <i>Spring Hill Cemetery</i>		22d. LOCATION (City, town, or county) (State) <i>Easton, Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Maurice A. Newman &amp; Son</i>				ADDRESS <i>Easton, Md.</i>		24a. REC'D BY REGISTRAR <i>DATE 5/23/57</i>	
24b. REGISTRAR'S SIGNATURE <i>N.H. Newman</i>							

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03345

CERTIFICATE OF DEATH

04481

Reg. Dist. No. 290

1. PLACE OF DEATH a. COUNTY <b>TALBOT</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>CAROLINE</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>EASTON</b>				c. LENGTH OF STAY IN 1b <b>2 DAYS</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>MEMORIAL</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>DENTON 05x02</b>			
				d. STREET ADDRESS			
				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>CHARLIE</b> First <b>DICKERSON</b> Middle <b>DICKERSON</b> Last				4. DATE OF DEATH <b>MARCH 31</b> Month <b>19 57</b> Day Year			
5. SEX <b>M</b>	6. COLOR OR RACE <b>C</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 1, 1886</b>	9. AGE (In years last birthday) <b>70</b> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Carver</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Farm</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>JAMES DICKERSON</b>				14. MOTHER'S MAIDEN NAME <b>CAROLINE</b> ?			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>?</b>		17. INFORMANT <b>Mabel Dickerson - Denton R.D.</b> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Heart failure</b> <b>450.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Coronary dilatation &amp; hypertrophy</b> DUE TO <b>Advanced arteriosclerosis</b> (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at <b>7:15 P.M.</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>E.C.H. Schmidt</b> M.D.				ADDRESS (Street, city or town, state) <b>219 S. Washington St., Easton 16, Maryland</b>			
PHYSICIAN'S NAME (Type) <b>E.C.H. Schmidt</b>				DATE SIGNED <b>April 5, 1957</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>4/4/57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Denton</b>		22d. LOCATION (City, town, or county) (State) <b>Denton Md</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>J.J. Frampton Son Federalburg Md</b>				24a. REC'D BY REGISTRAR <b>4/4/57</b>		24b. REGISTRAR'S SIGNATURE <b>N.H. Newmyer</b>	



# CERTIFICATE OF DEATH

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON

SEE INSTRUCTIONS

1. NAME OF DECEASED <i>JOHN J. BROWN</i>		2. SEX <i>MALE</i>		3. AGE <i>45</i>	
4. DATE OF DEATH <i>APR 8 1957</i>		5. TIME OF DEATH <i>10:30 AM</i>		6. PLACE OF DEATH <i>HOME</i>	
7. CAUSE OF DEATH <i>HEART DISEASE</i>		8. MANNER OF DEATH <i>NATURAL</i>		9. SIGNATURE OF PHYSICIAN <i>[Signature]</i>	
10. SIGNATURE OF REGISTRAR <i>[Signature]</i>		11. SIGNATURE OF WITNESS <i>[Signature]</i>		12. SIGNATURE OF DECEASED <i>[Signature]</i>	

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13. NAME OF CITY OR TOWN <i>BOSTON</i>		14. NAME OF COUNTY <i>SUFFOLK</i>	
15. NAME OF DECEASED <i>JOHN J. BROWN</i>		16. NAME OF DECEASED <i>JOHN J. BROWN</i>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 03351 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. **03350 290**

1. PLACE OF DEATH a. COUNTY <b>Talbot</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Talbot</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cordova</b>		c. LENGTH OF STAY IN 1b <b>6 months</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Easton 40</b> d. STREET ADDRESS <b>113 N. Harrison St.</b>	
3. NAME OF DECEASED (Type or print) <b>ZELLA DOOLING</b>		4. DATE OF DEATH Month <b>March</b> Day <b>10</b> Year <b>19 57</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec. 10, 1881</b>
9. AGE (In years last birthday) <b>75</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Railroad</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>Washington Dooling</b>		14. MOTHER'S MAIDEN NAME <b>Annie Fleetwood</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)	
17. INFORMANT <b>Mr. George D. Dooling</b>		Address <b>Fishing Creek, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary occlusion</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause lost. DUE TO (c) <b>420.1</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <b>minutes</b>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>found dead in privy, washbasin on floor, dc3P-body found c8p</b>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>No injury</b> 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <b>Louis S. Welty</b>		DATE SIGNED <b>3-12-57</b>	
EXAMINER'S NAME (Type) <b>Dr. Louis S. Welty</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>Mar. 14, 1957</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Spring Hill Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Easton, Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Maurice E. Newnam &amp; Son</b>		24a. REC'D BY REGISTRAR DATE <b>3/14/57</b>	
ADDRESS <b>Easton, Maryland</b>		24b. REGISTRAR'S SIGNATURE <b>N.H. Neenan</b>	

BUREAU V. 5

MAR 15 1957

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may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03346

CERTIFICATE OF DEATH

03351

Reg. Dist. No.

290

1. PLACE OF DEATH a. COUNTY <u>TALBOT</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>TALBOT</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>EASTON</u>				c. LENGTH OF STAY IN 1b <u>10 mins.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>MEMORIAL</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>MARGARET</u> First Middle Last <u>GOLDSBOROUGH</u>				4. DATE OF DEATH Month <u>MARCH</u> Day <u>10</u> Year <u>1957</u>			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>NOV. 19, 1881</u>	
9. AGE (In years lost birthday) <u>75</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY			
				11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>			
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>MATHEW T. GOLDSBOROUGH</u>				14. MOTHER'S MAIDEN NAME <u>IDA B. LOUD</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
				17. INFORMANT Address <u>MRS. DOROTHY BANGHART, EASTON, MD.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1 Congestive Heart Failure</u> DUE TO (b) <u>Myocardial Infarction</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <u></u> DUE TO (d) <u></u> DUE TO (e) <u></u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour <u>a. ft.</u> Month, Day, Year <u>19</u> p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> of work			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>June</u> , 19 <u>55</u> to <u>March 10</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>March 10</u> , 19 <u>57</u> , and that death occurred at <u>8:40 P.</u> M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Donald A. Bentley</u> M.D.				ADDRESS (Street, city or town, state) <u>97 N. Hanson St. - Easton, Md.</u>			
DATE SIGNED <u>3-10-57</u>							
PHYSICIAN'S NAME (Type) <u></u>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>3-14-57</u>		<u>Youngs Hill</u>		<u>Easton Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John D. Williams</u> ADDRESS <u></u>				24a. REC'D BY REGISTRAR DATE <u>3/14/57</u>		24b. REGISTRAR'S SIGNATURE <u>N. H. Neer</u>	

MAR 19 1957

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03352

03355

## CERTIFICATE OF DEATH

Reg. Dist. No. 290

1. PLACE OF DEATH a. COUNTY <b>Talbot</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Talbot</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Easton</b>		c. LENGTH OF STAY IN 1b <b>7 years</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Easton</b>		d. STREET ADDRESS <b>"Baskerville" at "Waverly"</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>"Baskerville" at "Waverly"</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Winter</b> Middle <b>Melbourne</b> Last <b>Hart</b>		4. DATE OF DEATH Month <b>March</b> Day <b>13</b> Year <b>1957</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec. 13, 1889</b>
9. AGE (In years last birthday) <b>67</b> yrs.		IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>	IF UNDER 24 HRS. Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Attorney</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Law Profession</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Alfred I. Hart</b>		14. MOTHER'S MAIDEN NAME <b>Gora Winter</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>unknown</b>		16. SOCIAL SECURITY NO. <b>none</b>	
17. INFORMANT <b>Mrs. Mildred W. Hart</b>		Address <b>Easton, MD, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Vascular Accident</b> DUE TO <b>Anterior-sclerosis - generalized</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>- yrs.</b> DUE TO (c) <b>- yrs.</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1 WK.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <input type="checkbox"/> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>6-8-</b> , 19 <b>56</b> , to <b>3-13-</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>3-13-</b> , 19 <b>57</b> , and that death occurred at <b>9 P.</b> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Donald A. Bentley</b>		ADDRESS (Street, city or town, state) <b>9 N. Hanson St. Easton, Md.</b>	
PHYSICIAN'S NAME (Type) <b>J</b>		DATE SIGNED <b>3-14-57</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Mar 16, '57</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Louden Park Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>W. Hampton Gwinn</b>		ADDRESS <b>EASTON, MD.</b>	
24a. REC'D BY REGISTRAR <b>DATE 3-16-57</b>		24b. REGISTRAR'S SIGNATURE <b>N. H. Neenan</b>	

BUREAU V. J.

26 26 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03353

## CERTIFICATE OF DEATH

Reg. Dist. No.

29!

1. PLACE OF DEATH a. COUNTY <b>Talbot</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Talbot</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Tilghman</b>		c. LENGTH OF STAY IN 1b <b>Life</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>22 Tilghman</b>	
f. STREET ADDRESS <b>1</b>		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Robert</b> Middle <b>T.</b> Last <b>Jackson</b>		4. DATE OF DEATH Month <b>March</b> Day <b>25</b> Year <b>1957</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 6, 1871</b>
9. AGE (In years last birthday) <b>85</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Oysterman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Oyster</b>	
11. BIRTHPLACE (State or foreign country) <b>Tilghman, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Unknown</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>220-32-0360</b>	
17. INFORMANT <b>Mrs. Myrtle Scharch</b>		Address <b>-8713 Summit Ave., Balto., Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary occlusion</b> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>arteriosclerosis, atherosclerosis, 10 years</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>5 months</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>1950</b> to <b>March 25, 1957</b> , that I last saw the deceased alive on <b>March 10, 1957</b> , and that death occurred at <b>4 p. m.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>Tilghman, Md. March 26, 1957</b>			
ACTUAL SIGNATURE <b>Wm. M. Reeser</b> M.D.			
PHYSICIAN'S NAME (Type) <b>Wm. M. REESER, M.D. TILGHMAN, MD</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>3/27/57</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Tilghman Methodist Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Tilghman Talbot Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>J. Seiders</b>		ADDRESS <b>Tilghman, Md.</b>	
24. RECEIVED BY REGISTRAR <b>Mar 28 1957</b>		24b. REGISTRAR'S SIGNATURE <b>Mar. R. R. Seth</b>	

CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH		OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH	
JAMES H. HARRIS		M		65		JAN 15 1892		BALTIMORE, MD		LABORER		HEART DISEASE		NATURAL	
RESIDENCE		DATE OF DEATH		PLACE OF DEATH		HOURS OF DEATH		TEMPERATURE		PULSE		RESPIRATION		BLOOD PRESSURE	
1234 E. BALTIMORE ST.		JAN 25 1957		BALTIMORE, MD		10:30 AM		100.0		90		20		120/80	
EDUCATION		RELIGION		MARRIAGE		SINGLE		MARRIED		WIDOWED		DIVORCED		OTHER	
HIGH SCHOOL		METHODIST		MARRIED		YES		YES		NO		NO		NO	
SIGNED BY		DATE		SIGNED BY		DATE		SIGNED BY		DATE		SIGNED BY		DATE	
J. H. HARRIS		JAN 25 1957		J. H. HARRIS		JAN 25 1957		J. H. HARRIS		JAN 25 1957		J. H. HARRIS		JAN 25 1957	
TESTED BY		DATE		TESTED BY		DATE		TESTED BY		DATE		TESTED BY		DATE	
J. H. HARRIS		JAN 25 1957		J. H. HARRIS		JAN 25 1957		J. H. HARRIS		JAN 25 1957		J. H. HARRIS		JAN 25 1957	

BUREAU V. S.

MAR 23 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03354

03347

## CERTIFICATE OF DEATH

Reg. Dist. No. 290

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Talbot</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>				c. LENGTH OF STAY IN TB <u>17 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Memorial Hospital</u>				d. STREET ADDRESS <u>R.F.D. #2 Box 178</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Richard</u> Middle <u>LESTER</u> Last <u>Jump</u>				4. DATE OF DEATH Month <u>March</u> Day <u>18</u> Year <u>1957</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>December 11, 1876</u> 80 yrs.	
9. AGE (In years last birthday)		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>BUILDING</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Edwin F. Jump</u>		14. MOTHER'S MAIDEN NAME <u>Marta Pauline Arringdale</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT <u>Mrs. Theresa C. Jump</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>thrombosis</u> <u>181X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Myocardial infarction</u> DUE TO (c) <u>Cocaine of bladder</u>				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour <u>o. 11</u> p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at <u>6:20 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>E.C.H. Schmidt</u>				ADDRESS (Street, city or town, state) <u>219 S Washington St Easton MD</u>			
PHYSICIAN'S NAME (Type) <u>E.C.H. Schmidt</u>				DATE SIGNED <u>3/20/57</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>3/20/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>SPRING HILL CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>Easton MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. Hampton</u>				ADDRESS <u>Easton MD</u>		24a. REC'D BY REGISTRAR <u>N.H. Nevin</u>	
DATE <u>3/20/57</u>				24b. REGISTRAR'S SIGNATURE <u>N.H. Nevin</u>			



RECEIVED

MAR 28 1957

BUREAU V. S.

Form with multiple sections and fields, including a large header area at the top and several smaller sections below. The text is mostly illegible due to blurring and low contrast. Some visible text includes "BUREAU V. S." and "RECEIVED".

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 14 FilmG212 3-26-57 et

03355

03343

CERTIFICATE OF DEATH

Reg. Dist. No. 290

1. PLACE OF DEATH a. COUNTY <b>Talbot</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Talbot</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Easton</b>				c. LENGTH OF STAY IN 1b <b>20 yrs</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>712 Dover St.</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>FRED HAROLD MCINTYRE</b>				4. DATE OF DEATH <b>March 12, 1957</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>May 10, 1910</b>	
9. AGE (In years last birthday) <b>46</b> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Auto Mechanic</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Indiana</b>	
13. FATHER'S NAME <b>Howard McIntyre</b>				14. MOTHER'S MAIDEN NAME <b>Verdie Haggard</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <b>218-12-1975</b>		17. INFORMANT <b>Mrs. Harriet McIntyre</b> Address <b>Easton, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Vertical Fibrillation</b> DUE TO <b>500x</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Acute laryngotracheobronchitis</b> DUE TO (c) <b>Days.</b>							INTERVAL BETWEEN ONSET AND DEATH <b>Minutes.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>7/11</b> , 19 <b>50</b> , to <b>1/28</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>1/28</b> , 19 <b>57</b> , and that death occurred at <b>9:30 A.M.</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Sheep, J.</b>				ADDRESS (Street, city or town, state) <b>Easton, Md.</b>		DATE SIGNED <b>3/13/57</b>	
PHYSICIAN'S NAME (Type) <b>Dr. Shepard Krech, Jr.</b>				Easton, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>March 15, 1957</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Spring Hill Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Easton, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Maurice E. Newnam &amp; Son</b>				ADDRESS <b>Easton, Maryland</b>		24a. REC'D BY REGISTRAR <b>3/15/57</b>	
						24b. REGISTRAR'S SIGNATURE <b>M. H. Newnam</b>	

CERTIFICATE OF DEATH

<p>1. NAME OF DECEASED</p>		<p>2. SEX</p>		<p>3. AGE</p>		<p>4. DATE OF BIRTH</p>	
<p>5. PLACE OF BIRTH</p>		<p>6. OCCUPATION</p>		<p>7. CAUSE OF DEATH</p>		<p>8. MANNER OF DEATH</p>	
<p>9. DATE OF DEATH</p>		<p>10. TIME OF DEATH</p>		<p>11. PLACE OF DEATH</p>		<p>12. SIGNATURE OF DECEASED</p>	
<p>13. SIGNATURE OF WITNESS</p>		<p>14. SIGNATURE OF PHYSICIAN</p>		<p>15. SIGNATURE OF CORONER</p>		<p>16. SIGNATURE OF JUDGE</p>	
<p>17. SIGNATURE OF CLERK</p>		<p>18. SIGNATURE OF REGISTRAR</p>		<p>19. SIGNATURE OF SHERIFF</p>		<p>20. SIGNATURE OF SHERIFF'S CLERK</p>	

BUREAU V. S.

MAR 19 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03356

03349

## CERTIFICATE OF DEATH

Reg. Dist. No. 290

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Talbot</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>EASTON</u>				c. LENGTH OF STAY IN 1b <u>8 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X1 Trappe</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Easton Memorial Hospital</u>				d. STREET ADDRESS <u>EASTON Md.</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>M.</u> Last <u>Phillips</u>				4. DATE OF DEATH Month <u>March</u> Day <u>19</u> Year <u>1957</u>					
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Jan 2, 1881</u> 76 yrs.			
9. AGE (In years last birthday) <u>76</u>				10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>			
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				13. FATHER'S NAME <u>Charles Phillips</u>					
14. MOTHER'S MAIDEN NAME <u>Emily Wood</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)					
16. SOCIAL SECURITY NO.				17. INFORMANT Address <u>Mrs. Clark Seibel, daughter - Trappe, Md.</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u> <u>151X</u> DUE TO <u>Cerebrum of stomach</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u></u> DUE TO <u></u> (c) <u></u>								INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>								19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)					
21. I certify that I attended the deceased from <u>Pathologist</u> , 19 <u>2/19</u> , to <u>2/19</u> , that I last saw the deceased alive on <u>2/19</u> , and that death occurred at <u>2:15 P.M.</u> from the causes and on the date stated above.									
ACTUAL SIGNATURE <u>E.C.H. Schmidt</u> M.D.				ADDRESS (Street, city or town, state) <u>219 S. Washington St. Easton, Md.</u>					
DATE SIGNED <u>19 March 1957</u>									
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3/22/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Tilghman Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Tilghman, Md.</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>William H. Harrison, Jr. Michael</u> ADDRESS <u></u>				24a. REC'D BY REGISTRAR <u></u> DATE <u>3/22/57</u>		24b. REGISTRAR'S SIGNATURE <u>N.H. Neer</u>			

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH		CITY OF BIRTH		COUNTY OF BIRTH		STATE OF BIRTH		CITY OF DEATH		COUNTY OF DEATH		STATE OF DEATH	
JAMES H. HARRIS		45		M		W		JAN 15 1892		CHICAGO		ILLINOIS		ILLINOIS		ILLINOIS		CHICAGO		ILLINOIS		ILLINOIS	
OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH		PERIOD OF ILLNESS		DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		COUNTY OF DEATH		STATE OF DEATH		CITY OF DEATH		COUNTY OF DEATH		STATE OF DEATH	
Carpenter		Heart Disease		Natural		Several Months		JAN 25 1937		CHICAGO		ILLINOIS		ILLINOIS		ILLINOIS		CHICAGO		ILLINOIS		ILLINOIS	
DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		COUNTY OF DEATH		STATE OF DEATH		CITY OF DEATH		COUNTY OF DEATH		STATE OF DEATH		CITY OF DEATH		COUNTY OF DEATH		STATE OF DEATH		CITY OF DEATH	
JAN 25 1937		CHICAGO		ILLINOIS		ILLINOIS		ILLINOIS		CHICAGO		ILLINOIS		ILLINOIS		CHICAGO		ILLINOIS		ILLINOIS		CHICAGO	
DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		COUNTY OF DEATH		STATE OF DEATH		CITY OF DEATH		COUNTY OF DEATH		STATE OF DEATH		CITY OF DEATH		COUNTY OF DEATH		STATE OF DEATH		CITY OF DEATH	
JAN 25 1937		CHICAGO		ILLINOIS		ILLINOIS		ILLINOIS		CHICAGO		ILLINOIS		ILLINOIS		CHICAGO		ILLINOIS		ILLINOIS		CHICAGO	

RECEIVED  
MAR 28 1937  
BUREAU V. S.



03350

## CERTIFICATE OF DEATH

Reg. Dist. No. 290

1. PLACE OF DEATH a. COUNTY <b>Talbot</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Talbot</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Easton</b>				c. LENGTH OF STAY IN 1b <b>life</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>421 August St.</b>				d. STREET ADDRESS <b>421 August St</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <b>JAMES LEE PRICE</b>				4. DATE OF DEATH <b>March 21, 1957</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>May 7, 1880</b>	
9. AGE (In years last birthday) <b>76</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Painter</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>							
13. FATHER'S NAME <b>George F. Price</b>				14. MOTHER'S MAIDEN NAME <b>Matilda Eason</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <b>220-32-0916</b>		17. INFORMANT <b>Mrs. Nannie Price</b> Address <b>Easton, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Thrombosis</b> <b>420.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Coronary Insufficiency</b> DUE TO (c) <b>Arteriosclerosis of Heart</b>				INTERVAL BETWEEN ONSET AND DEATH <b>1/2 hour</b> <b>years</b> <b>years</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>3-1</b> , 19 <b>57</b> , to <b>3-21</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>3-21</b> , 19 <b>57</b> , and that death occurred at <b>10:30 P.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Easton, Md.</b> DATE SIGNED <b>3-23-57</b>							
ACTUAL SIGNATURE <b>Dr. F. Buell</b> M.D. <b>Easton, Md.</b>							
PHYSICIAN'S NAME (Type) <b>Dr. Martin F. Buell</b> <b>Easton, Md.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Mar. 25, 1957</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Spring Hill Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Easton, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Maurice E. Newnam &amp; Son</b>				ADDRESS <b>Easton, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>3/25/57</b>	
				24b. REGISTRAR'S SIGNATURE <b>N. H. Newnam</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF DEATH		PLACE OF DEATH	
JAMES H. HARRIS		45		M		W		JAN 2 1980		AT HOME	
RESIDENCE		OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH		SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR	
1234 MAIN ST, BETHLEHEM, PA		FARMER		HEART DISEASE		NATURAL		[Signature]		[Signature]	
DATE OF BIRTH		PLACE OF BIRTH		EDUCATION		MARRIAGE		PREVIOUS ILLNESS		PREVIOUS SURGERY	
JAN 1 1935		PA		HIGH SCHOOL		MARRIED		NONE		NONE	
DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR	
JAN 2 1980		AT HOME		HEART DISEASE		NATURAL		[Signature]		[Signature]	

BUREAU V. S.

MAR 28 1980

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

03351 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
**CERTIFICATE OF DEATH**

03358

Reg. Dist. No. 290

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Caroline</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Denton 05 X02</u> ✓			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Memorial Hospital</u>				d. STREET ADDRESS <u>RT #2 Box 144 E.</u>			
3. NAME OF DECEASED (Type or print) First <u>Maurice</u> Middle <u>Samuel</u> Last <u>Sample</u>				4. DATE OF DEATH Month <u>March</u> Day <u>16</u> Year <u>1957</u>			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 4 1891</u>	9. AGE (In years last birthday) <u>65</u> yrs.	IF UNDER 1 YEAR Months <u>16</u> Days <u>19</u> Hours <u>57</u> Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Cannery</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		
13. FATHER'S NAME <u>John Samuel Sample</u>				14. MOTHER'S MAIDEN NAME <u>W. B. Kelburn</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)			16. SOCIAL SECURITY NO. <u>215-26-4084</u>		17. INFORMANT <u>Rebecca Sample</u> Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bacterial pneumonia</u> <u>491X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Chronic alcoholism</u> DUE TO (c) <u>(?)</u>						INTERVAL BETWEEN ONSET AND DEATH <u>48 hrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>3221</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Hour a. <u>11</u> Month <u>19</u> Day <u>19</u> Year <u>1957</u> p. m.			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>7 AM</u> , 19 <u>57</u> to <u>16 AM</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>16 AM</u> , 19 <u>57</u> , and that death occurred at <u>1:50 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Thorston Harrison</u> M.D.				ADDRESS (Street, city or town, state) <u>Easton</u>		DATE SIGNED	
PHYSICIAN'S NAME (Type) <u>THORSTON HARRISON</u>				<u>Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3-20-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Federal Hill</u>		22d. LOCATION (City, town, or county) (State) <u>Federalsburg Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>22 Frampton Ln Federalsburg Md</u> ADDRESS				24a. REC'D BY REGISTRAR <u>3/20/57</u>		24b. REGISTRAR'S SIGNATURE <u>N. S. Neer</u>	



1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03352

CERTIFICATE OF DEATH

Reg. Dist. No.

03359  
298

1. PLACE OF DEATH a. COUNTY <b>Talbot</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Talbot</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Easton</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>40 Easton</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>101 Idlewild Avenue</b>		d. STREET ADDRESS <b>127 S. Harrison St.</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>ELLEN</b> Middle <b>T.</b> Last <b>SLAUGHTER</b>		4. DATE OF DEATH Month <b>March</b> Day <b>19</b> Year <b>1957</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug. 14, 1881</b>
9. AGE (In years last birthday) <b>75</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Maryland</b>	
11. BIRTHPLACE (State or foreign country) <b>U.S.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>James H. Warner</b>		14. MOTHER'S MAIDEN NAME <b>Elizabeth Virginia Fox</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>Mr. Emory Slaughter</b>	
17. INFORMANT <b>Easton, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Infarction</b> DUE TO <b>420.1</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic Coronary Disease</b> DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <b>1 day</b> <b>?</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>3/18/57</b> to <b>3/19/57</b> , that I last saw the deceased alive on <b>3/18/57</b> , and that death occurred at <b>9:30 A.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Easton Md</b> DATE SIGNED			
ACTUAL SIGNATURE <b>Dr. P. Evans Cox</b> M.D.			
PHYSICIAN'S NAME (Type) <b>Dr. P. Evans Cox</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>March 21, 1957</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Spring Hill Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Easton, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Maurice E. Newnam &amp; Son</b>		24a. REC'D BY REGISTRAR <b>DATE 3/21/57</b>	
24b. REGISTRAR'S SIGNATURE <b>N. H. Neer</b>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

Form with multiple sections for recording death information, including fields for name, date, time, place, cause, and signature. The form is oriented horizontally but contains vertical text labels for various fields.

BUREAU V. S.

MAR 28 1957

RECEIVED

03357

## CERTIFICATE OF DEATH

Reg. Dist. No. 291

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Ind</u> b. COUNTY <u>Talbot</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>St. Michaels Md</u>				c. LENGTH OF STAY IN 1b <u>Life</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>William</u> First <u>R.</u> Middle <u>True</u> Last				4. DATE OF DEATH Month <u>Mar</u> Day <u>11</u> Year <u>1957</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Sept 3 1873</u>	
9. AGE (In years last birthday) <u>83</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Agriculture</u>		11. BIRTHPLACE (State or foreign country) <u>St. Michaels, Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				13. FATHER'S NAME <u>Willis H. True</u>			
14. MOTHER'S MAIDEN NAME <u>Anna Dawson</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO.				17. INFORMANT <u>Mrs. Grace V. Trico, St. Michaels, Md.</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>cardiac failure - severe</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>arteriosclerotic cardiovascular</u> DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>3 weeks</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>asthma - severe - cardiac</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				(County)		(State)	
21. I certify that I attended the deceased from <u>12-8-1956</u> to <u>3-11-1957</u> , that I last saw the deceased alive on <u>3-11-1957</u> , and that death occurred at <u>10:30 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>[Signature]</u>				ADDRESS (Street, city or town, state) <u>St. Michaels Md.</u>			
PHYSICIAN'S NAME (Type) <u>Wm M Reeker Jr</u>				DATE SIGNED <u>3-12-57</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Mar 13-1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Wheat Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>St. Michaels Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. Hamilton Harrison, St. Michaels Md</u>				24a. REC'D BY REGISTRAR DATE <u>Mar 12-57</u>		24b. REGISTRAR'S SIGNATURE <u>Mrs R. R. Sette</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

DECEASED NAME [Illegible]		SEX [Illegible]		AGE [Illegible]	
PLACE OF BIRTH [Illegible]		DATE OF BIRTH [Illegible]		PLACE OF DEATH [Illegible]	
OCCUPATION [Illegible]		CAUSE OF DEATH [Illegible]		MANNER OF DEATH [Illegible]	
DATE OF DEATH [Illegible]		TIME OF DEATH [Illegible]		PLACE OF INTERMENT [Illegible]	
SIGNATURE OF DECEASED [Illegible]		SIGNATURE OF WITNESS [Illegible]		SIGNATURE OF PHYSICIAN [Illegible]	
SIGNATURE OF CLERK [Illegible]		SIGNATURE OF REGISTRAR [Illegible]		SIGNATURE OF JUDGE [Illegible]	

BUREAU V. R.

MAR 15 1957

RECEIVED

03353 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
 CERTIFICATE OF DEATH

03361

Reg. Dist. No. 290

1. PLACE OF DEATH a. COUNTY <b>Talbot</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Talbot</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Easton</b>				c. LENGTH OF STAY IN TB <b>10 yrs.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Lucy</b> Middle <b>E.</b> Last <b>Watts</b>				4. DATE OF DEATH Month <b>March</b> Day <b>4</b> Year <b>1957</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Feb. 17, 1876</b>	
9. AGE (In years last birthday) <b>81</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY -----	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		13. FATHER'S NAME <b>Frances Fitzgerald</b>		14. MOTHER'S MAIDEN NAME <b>Elexona Phillips</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. -----		17. INFORMANT <b>Mrs. Dora Pahlman</b>		Address <b>Easton, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Congestive Heart Failure</b> <b>420.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic Heart Disease</b> DUE TO (c) -----				INTERVAL BETWEEN ONSET AND DEATH <b>Hours</b> <b>yrs.</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Rheumatoid Arthritis.</b>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		21. I certify that I attended the deceased from <b>9/17</b> , 19 <b>57</b> , to <b>3/4</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>3/4</b> , 19 <b>57</b> , and that death occurred at <b>4:30 P. M.</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Shepard Krech, Jr.</b>		M.D. <b>Easton, Md.</b>		DATE SIGNED <b>3/5/57</b>		ADDRESS (Street, city or town, state)	
PHYSICIAN'S NAME (Type) <b>Dr. Shepard Krech, Jr.</b>		22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Mar. 7, 1957</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Upper Bambury Cemetery</b>	
22d. LOCATION (City, town, or county) (State) <b>Trappe (Rural) Maryland</b>		23. FUNERAL DIRECTOR'S SIGNATURE <b>Maurice E. Newnam &amp; Son</b>		ADDRESS <b>Easton, Md.</b>		24a. REC'D BY REGISTRAR <b>3/7/57</b>	
24b. REGISTRAR'S SIGNATURE <b>M. A. Newnam</b>							

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03353

CERTIFICATE OF DEATH

03362

Reg. Dist. No. 290

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Caroline</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Federalburg, Md.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Easton Memorial Hosp.</u>				d. STREET ADDRESS <u>05X22</u>			
3. NAME OF DECEASED (Type or print) First <u>Leonard</u> Middle <u>F.</u> Last <u>Williamson</u>				4. DATE OF DEATH Month <u>3</u> Day <u>17</u> Year <u>1957</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Sept. 4 1894</u> (62 yrs.)	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Automobile Dealer</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Mr. Leonard Williamson</u>				14. MOTHER'S MAIDEN NAME <u>Anna Hoyt</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>330X</u>		17. INFORMANT <u>Mrs. Elizabeth Williamson</u>		Address <u>12 hrs.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Subarachnoid hemorrhage</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>12 hrs.</u> DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour <u>a. m.</u> <u>19</u> p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>16 hrs.</u> , 19 <u>57</u> , to <u>17 hrs.</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>17 hrs.</u> , 19 <u>57</u> , and that death occurred at <u>10-9</u> M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Thurston Harrison</u>				ADDRESS (Street, city or town, state) <u>Federalburg, Md.</u>			
PHYSICIAN'S NAME (Type) <u>THURSTON HARRISON</u>				DATE SIGNED <u>19 hrs 57</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3/20/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Hillcrest Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Federalburg, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Stacey Williams</u>				ADDRESS <u>Federalburg, Md.</u>		24a. RECEIVED BY REGISTRAR <u>N. A. Neer</u>	
				DATE <u>3/20/57</u>		24b. REGISTRAR'S SIGNATURE	

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH		CITY OF BIRTH		COUNTRY OF BIRTH	
JAMES EARL RAY		35		M		W		1922		MOBILE, ALABAMA		MOBILE		UNITED STATES	
DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		DISEASE OR INJURY		PERIOD OF ILLNESS		TREATMENT		POSTMORTEM	
APRIL 4, 1968		MEMPHIS, TENNESSEE		SHOOTING		HOMICIDE		GUNSHOT WOUNDS OF THE CHEST AND BACK		SEVERAL DAYS		HOSPITAL		NO	
SIGNATURE OF PHYSICIAN		SIGNATURE OF CORONER		SIGNATURE OF WITNESS		SIGNATURE OF DECEASED		SIGNATURE OF NEXT OF KIN		SIGNATURE OF MINISTER		SIGNATURE OF CHURCH		SIGNATURE OF FUNERAL HOME	
[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]	
DATE		PLACE		CITY		STATE		COUNTRY		COUNTY		TOWNSHIP		PARISH	
APRIL 4, 1968		MEMPHIS		TENNESSEE		UNITED STATES		MEMPHIS		SHADETREE		MEMPHIS		MEMPHIS	

BUREAU V. 3

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 4 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 4, 8, 9 Film 6212 3-20-57 et

03363

MEDICAL EXAMINERS

CERTIFICATE OF DEATH

Reg. Dist. No.

796

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> <u>03359</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Talbot</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Trappe</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Trappe Rt 2</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Route 2</u>		d. STREET ADDRESS <u>1</u>	
3. NAME OF DECEASED (Type or print) First <u>James</u> Middle <u>Curtis</u> Last <u>Wilson</u>		4. DATE OF DEATH Month <u>3</u> Day <u>5</u> Year <u>1957</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Col.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8/10/92?</u>
9. AGE (In years last birthday) <u>65</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u>5</u> Days <u>19</u> Hours <u>57</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Factory</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Salomon Wilson</u>		14. MOTHER'S MAIDEN NAME <u>Isabella Hughes</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>213-22-5500</u>	
17. INFORMANT <u>Miss Matie Wilson, Easton Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Asphyxiation-caught in burning house-body partly consumed</u> 916.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>see #16</u>	
20c. TIME OF INJURY Hour <u>9</u> o. m. <u>P</u> Month, <u>3</u> Day, <u>5</u> Year <u>57</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>cannery shack</u>		20f. (City or town) (County) (State) <u>nr Trappe Talbot Md</u>	
21. I certify that the deceased was <u>HELD INSPECTION</u> to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at <u>9 &amp; P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Easton, Md.</u> DATE SIGNED <u>3-7-57</u>			
ACTUAL SIGNATURE <u>Louis S. Welty</u> M.D. <u>DME</u>			
PHYSICIAN'S NAME (Type) <u>Louis S. Welty</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>3/9/57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Daytown Cem</u>		22d. LOCATION (City, town, or county) (State) <u>Easton, Rt 4, Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Louis S. Welty</u>		24a. REC'D BY REGISTRAR <u>151957</u>	
ADDRESS <u>Easton, Md.</u>		24b. REGISTRAR'S SIGNATURE <u>Mrs. N. A. Gowing</u>	

CERTIFICATE OF DEATH

DATE OF DEATH		PLACE OF DEATH	
MAY 15 1957		BALTIMORE, MD	
AGE		SEX	
45		F	
RACE		EDUCATION	
W		H	
OCCUPATION		MANNER OF DEATH	
Nurse		Natural	
CAUSE OF DEATH		IMMEDIATE CAUSE	
Coronary Thrombosis		Myocardial Infarction	
DISEASE OR INJURY		SYMPTOMS	
Chest pain, shortness of breath		Sudden onset	
Duration of illness		Time of death	
2 days		5:15 PM	
Physician		Attending Physician	
J. H. Smith, M.D.		J. H. Smith, M.D.	
Signature		Signature	
J. H. Smith		J. H. Smith	
Date		Date	
May 15, 1957		May 15, 1957	

RECEIVED  
MAR 15 1957  
BUREAU V. S.